STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505272	A. BUILDING _____ B. WING _____	C 08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MOUNT VERNON	2120 EAST DIVISION STREET MOUNT VERNON, WA 98273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Life Care Center, Mt Vernon on 08/12/2013 and 08/21/2013. A sample of 9 residents was selected from a census of 82. The sample included 8 current residents and the records of 1 former/discharged resident.

The following complaints were investigated as part of this survey:

2841601
2847198
2850843

The survey was conducted by:

[redacted] R.N., M.S.

The survey team was from:
Department of Social and Health Services
Aging and Long Term Services Administration
Residental Care Services, District 2, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223
Telephone: (360) 651-6850
FAX: (360) 651-6940

8/24/13
Residential Care Services Date

RECEIVED
SEP 05 2013
ADSA/RCS
Smokey Point

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

9/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 9/4/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to acknowledge and address Resident 1's concerns for treatment in a timely manner. Failure to promptly discuss and respond to Resident 1's concerns regarding the 1:1 continuous supervision resulted in his feeling "frustrated and depressed" and physically hitting himself in front of staff in response to the lack of resolution to his perceived "punishment."

Findings include:

Resident 1 admitted to the facility in [redacted] 2013 for rehabilitation after a [redacted] His Minimum Data Set assessment, dated 07/21/13, identified his recall and memory as intact (15/15 points on the memory assessment tool). He exhibited no disruptive physical or verbal behaviors. On 06/21/13, Resident 1 signed a document reading he had received and understood the facility smoking policy. That policy identified the facility as a non-smoking facility. Residents and staff were allowed to smoke "off property only."

On 06/27/13 Resident 1 smoked marijuana, which he stated he had a physician order for, in his room. Staff explained it was against facility policy to smoke marijuana. Resident 1 agreed

F 241

Correction as it relates to the resident:
Resident 1 no longer resides in facility.

Action taken to protect residents in similar situations:
Residents on one to one observation have the potential to be affected and have had an interdisciplinary team (IDT) meeting to review current intervention and update the plan of care as needed.

Measures taken or systems altered to ensure the problem does not recur:
The interdisciplinary team (including social services, nursing, and activities) will be educated by the Regional Nurse on care plan development and care conferences/IDT meetings for residents requiring one-to-one observation.

The facility will have a weekly care conference and/or interdisciplinary team meeting to discuss identified issues and further care plan development for residents that are receiving one-on-one services.

9/10/13

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F 241	Continued From page 2 not to smoke again during his time in the facility. On 07/14/13, Resident 1 again smoked marijuana in his room. Staff reiterated no residents were allowed to smoke marijuana on the premises. Resident 1 signed a copy of the "non-smoking policy" and was placed on 15 minutes checks for 7 days. He exhibited no attemnpts to moke during that time. On 07/31/13 staff placed Resident 1 on continuous 1:1 supervision, meaning a staff member accompanied Resident 1 at all times, 24 hours/day, wherever he went or whatever he did. Review of the clinical record of Resident 1 dated, 08/02/13, identified this action was initiated "to monitor for his smoking behavior." On 08/12/13 at 9:55 a.m., Resident 1 reported he could not go outside without a doctor's permission. Staff continued to bring up - "you smoked." At 1:43 p.m., observation found 7 staff members outside the door to Resident 1's room. Resident 1 reported, " They are paid to watch me like dogs. It makes me feel horrible ...I feel like I am more in jail than in a place to get better." On 08/21/13 at 10:20 a.m., Resident 1 reported he had 1:1 24 hour 7 day monitoring. He stated he had no space. If his leg was not broken, he would walk out. It felt "punitive - like go sit in the corner. You are a bad boy." Having someone sit outside the door to his room "seemed wrong, like jail." Resident 1 stated he told the Director of Nursing (DNS) and Administrator he did not like the 1:1 monitoring several times. No one had spoken to him about changing it. On 08/22/13 at 1:15 p.m., the DNS reported she was aware Resident 1 did not like the 1:1	F 241	**Plans to monitor performance to ensure solution is sustained:** A weekly audit will be completed by the Director of Nursing of residents receiving one-to-one services to verify weekly care conference/IDT meeting occurred and appropriate interventions or follow up was completed. The trends form these audits will be presented to the facility Performance Improvement committee for 3 months to ensure ongoing compliance and / or needed system revision. **Date Certain:** 9/10/13 **Title of Person Responsible for Compliance:** The Executive Director	9/10/13

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F 241	Continued From page 3	F 241		

supervision 24 hours a day, 7 days a week. He had told her more than once. She was present when he hit his head on 08/07/13 in his attempt to get staff to listen to him. When he was accompanied by 1:1 supervision on an outing to the grocery store on 08/14/13, Resident 1 purchased and drank a beer in front of the 1:1 accompanying staff member. She thought he did this as "retaliation" for the continuous 1:1 supervision. She was aware he had made no attempts to smoke since 07/14/13. She had no additional information why the facility did not meet with Resident 1 to address his feelings of the 24 hour continuous monitoring.

On 08/23/13 at 10:29 a.m., the Divisional Nurse reported she advised the facility leadership to place Resident 1 on 1:1 supervision 24 hours/day 7days/week on 07/31/13. She did not know the resident and had not reviewed his clinical record. She was certain she would not like 1:1 supervision for herself, but her bigger focus was safety of all the residents in the building. She reported staff should hold a care conference as soon as possible after initiating 1:1 supervision and figure out what to do for a long term solution other than 1:1 supervision for any resident.

Review of the clinical record of Resident 1 revealed on 08/07/13, nursing documented Resident 1 told the DNS he no longer needed 1:1 supervision. He felt "frustrated" by the 1:1 supervision and thought it was "making him feel depressed." Resident 1 began to "hit his head." He stated if he "hit his head so hard, maybe someone will listen." On 08/11/13, nursing documented Resident 1 requested to leave the premises of the facility. He was informed he may not leave. Resident 1 became "angry and

9/10/13

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F 241	Continued From page 4 argumentative, stating he "is a prisoner of the facility." On 08/14 13 Resident 1 left the premises accompanied with the 1:1 staff supervision. He went to a nearby grocery store and purchased a beer, which he drank there in front of the staff member. He told the staff he is 60 years old and "can do whatever he wants." There was no evidence of any documentation of any attempts to smoke after 07/14/13.	F 241		

9/10/13